DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505188	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FEDERAL WAY	1045 SOUTH 308TH STREET FEDERAL WAY, WA 98003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		11/22/13

This report is the result of an unannounced Abbreviated Survey conducted at Life Care Center of Federal Way on 11/20/13. Seven current residents were sampled, from a census of 109 residents.

The following were complaints investigated as part of this survey:

#2909529, 2908307, 2909149, 2909152

The survey was conducted by:

[redacted] MSN, RN, Complaint Investigator

The survey team is from:

Department of Social & Health Services
Aging & Disability Services Administration
Residential Care Services, District 2, Unit F
20425 72nd Avenue South, Suite 400
Kent, WA 98032-2388

Telephone: (253) 234-6048
Facsimile: (253) 395-5070

Mike Anbesse 11-26-13
Residential Care Services Date

This plan of correction is submitted as required under Federal and state regulations and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.

Please accept this Plan of Correction as our credible allegation of compliance. Our compliance will be achieved by the date identified on the plan of correction.

RECEIVED
DEC 05 2013
DSHS/ADSA/RCS Region 4

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Owens	Executive Director	12/2/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505188	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FEDERAL WAY	1045 SOUTH 308TH STREET FEDERAL WAY, WA 98003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement their polices /procedures by initiating an investigation and report to the appropriate entities in a timely manner, and prevent further abuse as required following an allegation of abuse involving two of seven residents reviewed for abuse. This failure placed Resident #2 and other residents at risk of being repeatedly abused. Findings included: According to the 11/06/13 Minimum Data Set (MDS) Resident #1 was severely impaired for decision-making after experiencing a [redacted] injury and was able propel to a wheelchair with limited staff assistance. According to the 10/14/13 MDS Resident #2 was severely cognitively impaired, had a diagnosis of [redacted] disease and required extensive assistance for locomotion and other activities of daily living. Both Residents were observed sleeping on 11/20/13 at 6:00 a.m. According to the facility's July 2011 Protection of Residents: Reducing the Threat of Abuse and Neglect policy; ...All personnel will promptly report any incident or suspected incident of resident	F 226	F226 1. As soon as facility was made aware of incident. DNS started investigation immediately, placed call to state hotline, educated involved staff on abuse and neglect and mandatory reporter guidelines. Involved staff were suspended. 2. In-house personnel files review of all employees for validation of abuse and neglect training inclusive of Elder Justice Act. All staff training on Mandatory Reporting and abuse recognition per facility policy. 3. Abuse and neglect comprehension audit weekly x 4 weeks and monthly x 3 months. 4. Results will be reviewed in PI with further education as warranted. 5. 11/22/13 6. Director of Nursing or designee to ensure compliance. RECEIVED DEC 05 2013 CMS/ADSA/RCS Region 4	11/22/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505188	A. BUILDING _____ B. WING _____	C 11/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FEDERAL WAY	1045 SOUTH 308TH STREET FEDERAL WAY, WA 98003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 2 abuse and/or neglect,...to facility administration...must satisfy the immediate reporting requirement by notifying the (State)." Review of the facility's 11/19/13 evidence of investigation revealed five facility staff C, D, E, F and G had direct or indirect knowledge of Resident #1 touching Resident #2 in a sexually inappropriate manner and did not follow facility or State requirements for reporting actual or suspected abuse. Staff B said, in an interview on 11/21/13, Staff C observed Resident #1 touching Resident #2 inappropriately on 11/14/13 and informed Staff D about the incident the same day. Staff C did not inform the supervisor nor the state. Staff F and G became aware of the incident sometime 11/15/13 and also did not report to any Administrative staff or the State. The facility failed to initiate an investigation , report the allegation to the Administrator, law enforcement, the state agency , and prevent further potential abuse until 11/19/13. (Five days following the allegation).	F 226	11/22/13 RECEIVED DEC 05 2013 DSHS/ADSA/RCS Region 4	